Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS5818AGC	A. BUILDING _____ B. WING _____	C 03/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMEERY CARE	333 PRINCE GEORGE RD LAS VEGAS, NV 89183

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted on your facility 3/2/11 through 3/21/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 10 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was five. Five resident files were reviewed and four employee files were reviewed. The facility received a grade of A.	Y 000		
Y 026 SS=D	449.190(3) Contents of License-Multiple Types NAC 449.190 3. A residential facility may be licensed as more than one type of residential facility if the facility provides evidence satisfactory to the bureau that it complies with the requirements for each type of facility and can demonstrate that the residents will be protected and receive necessary care and services. This Regulation is not met as evidenced by: Based on observation, record review and interview on 3/2/11, the facility was caring for 2 of	Y 026		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 026	Continued From page 1 10 persons with mental illnesses without an endorsement and failed to obtain the necessary training to care for such persons (Resident #1 and #2). Severity: 2 Scope: 1	Y 026		
Y 445 SS=F	449.229(3) Exit doors NAC 449.229 3. An exit door in a residential facility must not be equipped with a lock which requires a key to open it from the inside unless approved by the State Fire Marshall or his designee. This Regulation is not met as evidenced by: Based on observation, the facility failed to ensure 1 of 2 primary exits was equipped with a lock that could be opened from the inside without a key (front door). Severity: 2 Scope:	Y 445		
Y 878 SS=D	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident:	Y 878		

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Y 878	Continued From page 2 (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by: Based on interview and record review from 3/2/11 through 3/21/11, the facility failed to ensure that 1 of 10 residents received medications as prescribed (Resident #1). This is a repeat deficiency from the 10/8/10 complaint investigation survey. Severity: 2 Scope: 1	Y 878		